Health Insurance Exchange

History and the Affordable Care Act

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INSURANCE EXCHANGE

1. Concept
2. History
3. Contemporary Exchanges
4. Affordable Care Act and Exchange

INSURANCE EXCHANGE CONCEPT

- Organizes private insurance market for consumers
- One stop health coverage eligibility
- Expands size of risk pool
- Facilitates federal subsidies for insurance

HISTORY OF EXCHANGES

- Specific trade or professional groups
- State operated small group exchange

- Federal Employees Health Benefits Program (FEHBP)
- Medicare Advantage

EXISTING STATE EXCHANGES

UTAH HEALTH EXCHANGE

HealthConnector

AFFORDABLE CARE ACT

- Passed March 23, 2010
- Extensively Debated but the law is the law
- Exchange concept has support from all political ideologies

- Duty to carry out law and protect WV interests
- Congressional changes to health reform not likely to impact core functions of exchange

ACA EXCHANGE TIMELINE

Timeline

- 2010 through 2015- HHS grant available
- January 1, 2013- HHS must know state's exchange plan
- January 1, 2014- State must implement exchange
- January 2015- Exchange must be financially self-sustaining
- January 2017- Large groups eligible for exchange

EXCHANGE OPERATION

- The Exchange must be operated by a governmental agency (Feds or State) or nonprofit entity
- The Exchange may only offer qualified plans to individuals or employers (dental plans can also be offered)
- The Exchange may offer plans with additional benefits but states must assume cost of mandates
- The Exchange must provide for:
  - Initial open enrollment period
  - Annual open enrollment period
  - Special enrollment periods

STRUCTURE OPTIONS

- States are to establish a Small Business Health Options Program, referred to as SHOP
- States may choose to establish a single exchange that performs both functions.

Regional Exchanges

- States may jointly form regional Exchanges or may form multiple subsidiary exchanges if each one serves a distinct geographic area.

ELIGIBILITY DETERMINATION

- Inform individuals of eligibility for Medicaid, CHIP or other applicable state or local public programs
- Inform consumers of eligibility for individual federal subsidies and cost sharing assistance
- Certify exemptions from individual mandate

- Eligibility to be based on Modified Adjusted Gross Income- rules not yet released
- Need to interface with Federal Government to verify citizenship and MAGI of consumer

FEDERAL SUBSIDY

Premium subsidies are based on second lowest cost silver plan

Consumer can select less expensive or more expensive plan and pay accordingly

FPL range for individuals*:

- 133FPL- $14,404- 2%
- 150FPL- $16,245- 4%
- 200FPL- $21,660- 6.3%
- 250FPL- $28,735- 8.05%
- 400FPL- $43,320- 9.5%

*Numbers are estimated provided by Kaiser Family Foundation and will be further studied once essential benefit regulations are available.

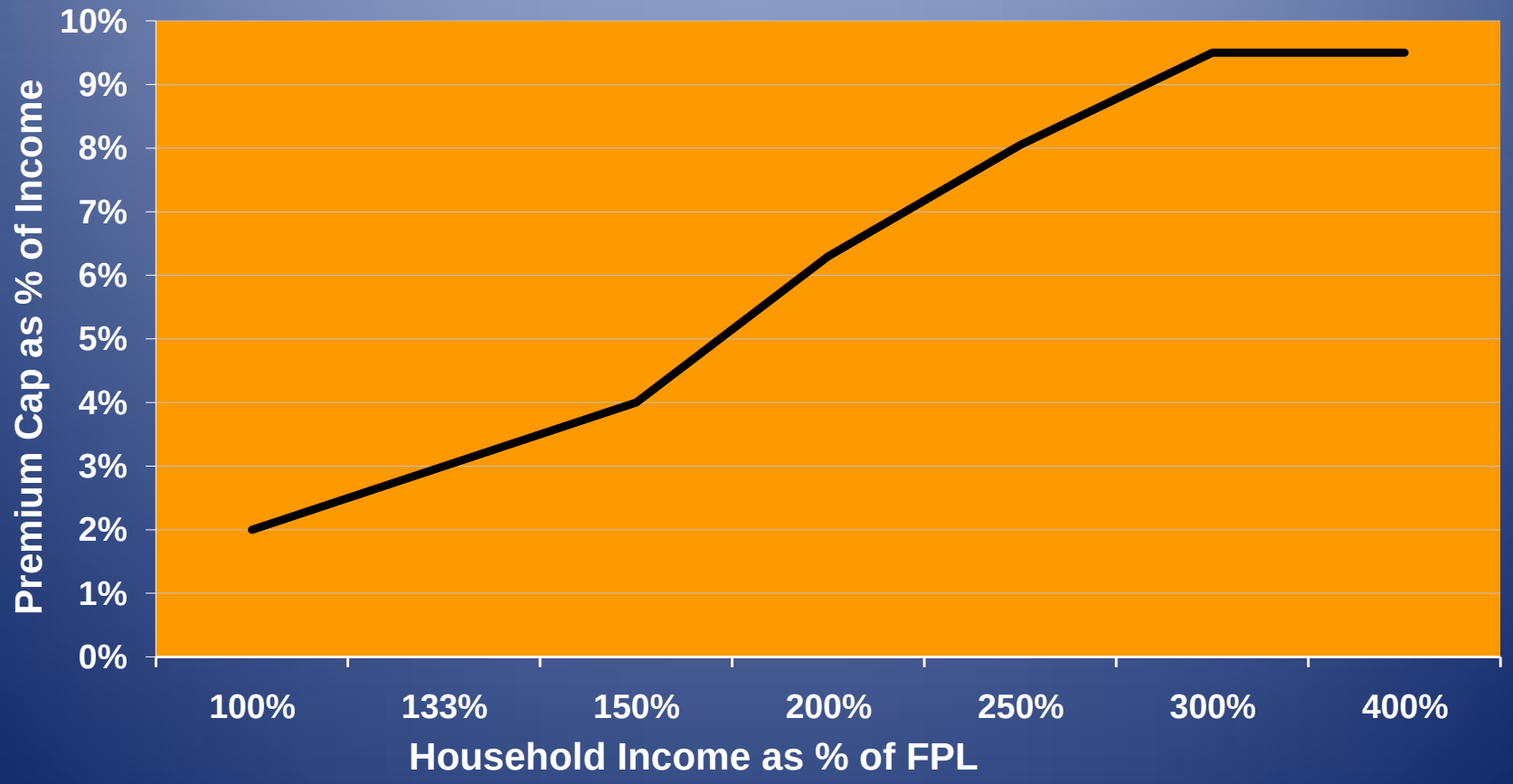
Ike is 45 years old and has an income in 2014 that is 250% of poverty.

The cost of the second lowest cost silver plan in the exchange in Ike's area is projected to be about $5,733

Ike pays no more than 8.05% of income, or approximately $2,310, for second lowest cost silver plan

*Numbers are estimated provided by Kaiser Family Foundation and will be further studied once essential benefit regulations are available.

Premium Tax Credits



SHOP EXCHANGES

- Small Group defined as 1-100 employees
- State may elect to define as 1-50 until January 1, 2016
- Currently state defines small group at 2-50
- State may elect to combine individual and small group (governance and/or pool)
- Interpretative debate over employer choice of plan
- Group members individually rated

SMALL BUSINESS TAX CREDIT

- Businesses with 25 or fewer employees
- Average wages less than $50,000
- Contribute at least 50% of premium
- Phases out as size and wages of business increase

- 2010-2013: Up to 35% of total employer contribution
- Beyond 2014: Up to 50% of contribution if purchased through exchange
- Beyond 2014, employer can only access tax credit for a cap of two years
- One-year carry back and a 20 year carry forward for unused credit

PLAN TIERS AND RATING

Levels of Coverage

Plans in exchange will fall within specified actuarially defined tiers:

Catastrophic Plan

Bronze- 60%

Silver- 70%

Gold- 80%

Platinum- 90%

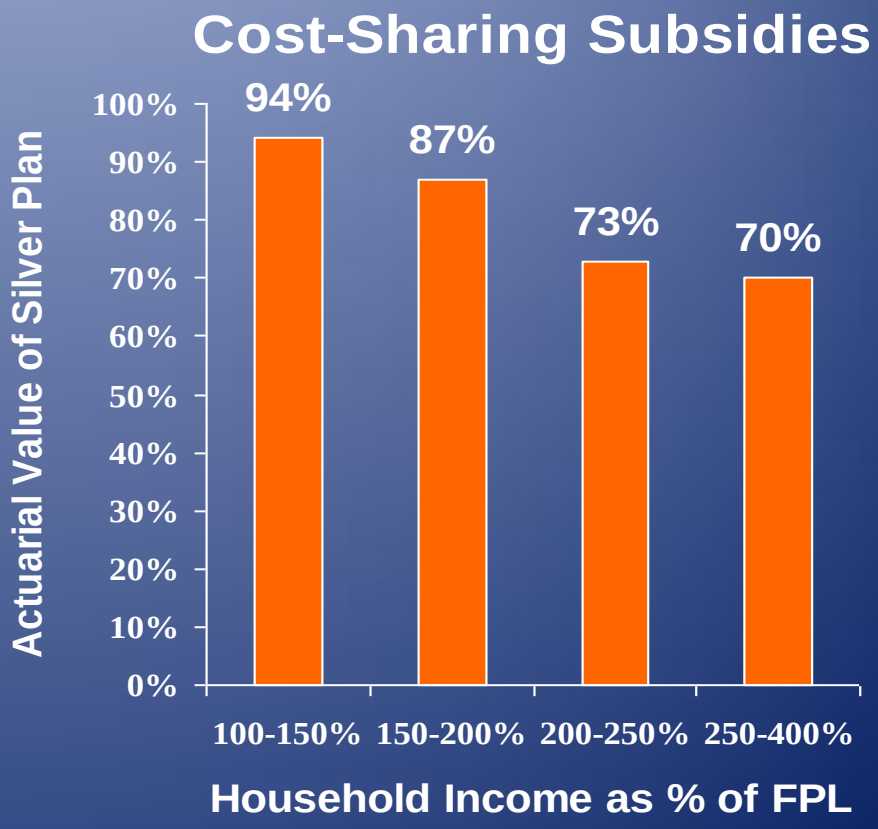
Rating

Limited Rating

- Age (3:1 maximum)
- Tobacco (1.5:1 maximum)
- Geographical rating area

COST SHARING SUBSIDIES

Income Level	Actuarial Value
100-150% FPL	94%
150-200% FPL	87%
200-250% FPL	73%



QUALIFIED HEALTH PLANS

- Provide essential benefits
- Carrier must:
  - be licensed and in good standing;
  - offer at least one silver and one gold plan;
  - charge same premium for plan in and out of exchange

EXCHANGE BENEFITS

ACA Benefits

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Behavioral health services

ACA Benefits

- Prescription drugs
- Rehab services and devices
- Laboratory services
- Preventive and wellness
- Chronic disease management
- Pediatric services- oral, vision

PLAN TRANSPARENCY

Plans must disclose:

- Claims payment policies and practices
- Periodic financial information
- Data on enrollment and disenrollment
- Number of claims denied
- Enrollee rights under ACA

Plans must disclose:

- Rating practices
- Cost-sharing and payments for out-of-network coverage
- Justification for any premium increase prior to implementation
- Other information required by the Secretary

NAVIGATOR GRANTS

- Section 1311 of ACA
- Agents and Brokers are specifically listed as eligible
- Duties:
  - Public education
  - Distribute impartial info about plans and subsidy
  - Facilitate enrollment
  - Provide referrals when consumer has complaint, grievance

- HHS shall establish rules for navigators
- HHS will establish criteria to ensure impartiality of navigators
- Navigators shall not receive any consideration from any issuer for enrollment of consumer in exchange plan
- Grants to come from operational funds in exchange

PRODUCERS and EXCHANGE

Section 1312 of ACA

- HHS Secretary shall establish procedures under which a state may allow agents or brokers
  - To enroll individuals and employers in any qualified health plans in exchange
  - To assist individuals in applying for premium tax credits and cost-sharing reductions in exchange

PROVIDER QUALITY

- HHS will develop guidelines for increased payment for quality
- Exchange plans must report on these efforts
- Quality improvements include:
  - Effective case management
  - Use of medical home
  - Prevention of hospital readmissions
  - Prevention of medical errors
  - Wellness initiatives

- In 2015, a qualified health plan may contract with
  - Hospital with greater than 50 beds only if hospital
    - Utilizes patient safety evaluation system
    - Implements comprehensive program for discharge planning
  - Health care provider only if plan to improve quality as the Secretary may require in regulation

OTHER EXCHANGE FUNCTIONS

- Operate toll free consumer hotline
- Use a standard format for presenting coverage options
- Certify mandate exemptions
- Establish a navigator program for education and outreach
- Inform consumers of eligibility for federal subsidy, Medicaid, CHIP

- Implement procedures for certification, recertification and decertification of health plans
- Assign a rating to each plan
- Make available a premium calculator
- Transfer to the Treasury a list of exempt individuals and employees eligible for tax credit

HHS RULES

- Develop a rating system to measure quality and price
- Develop an enrollee satisfaction survey system for plans with more than 500 enrollees
- Define the Essential Health Benefits
- Define role of navigators
- Define MAGI
- Set marketing requirements
- Determine sufficient choice of providers (no requirement to contract if provider does not accept payment rates)
- Develop uniform enrollment form in PPACA
- Determine standard format for presenting plan options